UPMC Health Plan

XELJANZ

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, please call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:	**Provider specialty:**
Provider first name:	**Provider last name:**
Provider phone #:	**Provider fax #:**

Patient name:	**Patient UPMC Health Plan Member ID #:**	**Patient DOB:**	**Patient age:**

Drug requested: ☐ **Brand** ☐**Generic**	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**
Diagnosis:		**Date of diagnosis:**	
Please indicate place of administration	☐Physician office ☐ Hospital/Clinic ☐ Patient home	**Will the medication be (select one):** ☐ Billed directly by the provider via JCODE JCODE: _____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			

Please complete the following for all diagnoses:

Please indicate disease severity ☐ Mild ☐ Moderate ☐ Severe

Date of most recent tuberculosis skin test: _____. Result of tuberculosis skin test: ☐ Positive ☐ Negative

Does the member currently have evidence of infection? ☐ Yes ☐ No

Is the member currently using another biologic Disease Modifying Antirheumatic Drug or potent immunosuppressant in combination with Xeljanz? ☐ Yes ☐ No
If yes, please provide name of medication: _____

Does the member have severe hepatic impairment? ☐ Yes ☐ No

Please indicate past medication(s) tried and failed:
(Xeljanz requires prior drug therapy with both preferred TNF products.)

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
☐ Methotrexate					
☐ Hydroxychloroquine					
☐ Leflunomide					
☐ Minocycline					
☐ Sulfasalazine					
☐ Cimzia					
☐ **ENBREL****					
☐ **HUMIRA****					
☐ Remicade					
☐ Simponi					

Please be sure to complete and include the 2nd page of this form.

****ENBREL AND HUMIRA ARE THE PREFERRED TNF PRODUCTS FOR UPMC HEALTH PLAN**

XELJANZ

Page 2

Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include the 1st page of this form.

Please indicate past medication(s) tried and failed:

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
☐ Other (please provide names):					

Please provide the following laboratory values:

Laboratory test	Date of test	Result (include units)
Absolute Neutrophil Count (ANC)		
Lymphocyte Count		
Hemoglobin		
ALT		
AST		
Total Cholesterol		
LDL Cholesterol		
HDL Cholesterol		
Triglycerides		

Please provide any additional information in the space below.